PRINTED: 03/08/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			B. WIN			- C	
		15K015	D. Will			01/0	6/2012
	ROVIDER OR SUPPLIER FRIENDS HOME HEAL	THCARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 326 E S MAIN ST GAS CITY, IN 46933			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		JLD BE	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS	3	G	000			
		eral home health complaint sulted in an Immediate led survey.					
		99617 - Substantiated. related to the allegation are					
	Survey date: Januar Extended survey dat 2012	y 3, 2012 es: January 4, 5, and 6,					
	Facility: 003961						
	Medicaid Vendor: 20	00466510					
	Surveyor: Susan E. S Marty Cod	Sparks, RN PHNS ons, RN PHNS					
	The facility was infor Jeopardy on 1/6/11 a	rdy was identified on 1/6/11. med of the Immediate at 6:00 PM. The Immediate uncorrected at survey exit.					
	providing home heals competency evaluati beginning January 6 2014, for being found Conditions of Paritici Patient rights; 484.14 administration; 484:1	ons for a period of 2 years , 2012, through January 6, d out of compliance with the pation 42 CFR 484.10 4 Organization, services, and 8 Acceptance of Patients,					
	'	edical Supervision; 484.30 es; and 484.36 Home Health					
		e Elder, MSN, BSN, RN					
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		JLTIPLE (.DING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		15K015	B. WIN	G		01/06/2012		
	OVIDER OR SUPPLIER	HCARE INC						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
G 000	Continued From page	e 1 7 11, 2012	G	000				
G 100	This survey report ha result of an IDR on 2/484.10 PATIENT RIG	-	G	100			1/16/12	
	Based on clinical recto patient's child, amb hospital record review determined the agence resolution to a complaint of 1 complaints the with the potential to a patients (See G 107) confidentiality of the pin 10 of 10 clinical recaffect all the agency's records stored in a ut safeguarded against 1 of 1 off-site storage	and failed to ensure the patients' medical information cords with the potential to a patients and clinical						
	resulted in the agence requirements of the C	of these systemic problems y's inability to meet the condition of Participation 42 Rights resulting in the 31 patients.						
	an Immediate Jeopar jeopardy was identified facility was notified of	g in the determination that dy existed. The immediate ed on 01/07/2012. The the Immediate Jeopardy on The Immediate Jeopardy						

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		15K015	B. WIN			C 01/06/2012		
	OVIDER OR SUPPLIER	THCARE INC	•	3	REET ADDRESS, CITY, STATE, ZIP CODE 126 E S MAIN ST GAS CITY, IN 46933			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APP DEFICIENCY)			(X5) COMPLETION DATE	
G 100 G 107	Continued From pag remained unremoved 484.10(b)(5) EXERO RESPECT FOR PRO	d at the survey exit. ISE OF RIGHTS AND		100 107			1/16/12	
	The HHA must inves patient or the patient regarding treatment furnished, or regarding patient's property by on behalf of the HHA	tigate complaints made by a						
	Based on clinical red to patient's child, am hospital record reviet failed to ensure there complaint filed by a f complaints that resul	not met as evidenced by: cord, complaint log, aide note bulance run record and w and interview, the agency was resolution to a amily member in 1 of 1 ted in patient harm with the the agency's patients. (#10)						
	included a complaint the patient's family me home health aide (HI addendum is several what she felt happen the agency felt what conclusion was "We negligent. We do fee obligation as they had log failed to show a me	t Form dated 11/4/11 filed on 11/2/11 at 10 AM by nember's friend saying the HA) was negligent. The pages of the aide sharing ed and two pages of what happened. The final do not feel our aide was el family failed to met their d promised." The complaint esolution to the complaint. 10, start of care 10/26/11,						

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		15K015	B. WIN	IG		C 01/06/2012	
	OVIDER OR SUPPLIER	HCARE INC		32	EET ADDRESS, CITY, STATE, ZIP CODE 26 E S MAIN ST 3AS CITY, IN 46933		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE TAG CROSS-REFERENCED		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ACTION SHOULD BE TO THE APPROPRIATE	
G 107	nursing (SN) 1-2 days 60 days and HHA 5-7 visit 3-5 visits a day. The plan of care cont monitor and assist with A. The "Faithful Home Health Aide" st (Employee A) went to AM. The HHA note d different than the prevalence of the p	e with orders for skilled a week, 1-2 hours a visit x days a week 1-3 hours a The patient was diabetic ained an order for the SN to the accuchecks PRN. Friends Home Healthcare neet evidenced the HHA the home on 11/1/11 at 8 oes not indicate care was vious day. The patient was diabetic ained an order for the SN to the accuchecks PRN. Friends Home Healthcare neet evidenced the HHA the home on 11/1/11 at 8 oes not indicate care was vious day. The patient is extremely the words, et very weak on R is so that she cannot hold her alled MD [medical doctor] et is cell phone. MD stated that if it is extremely the son as to if he wanted to the let pt. die @ home. MD is staff can do is to keep her so told writer that the pt. had in odor, et writer also for the worders, what MD said. When writer end, she stated she was she was shopping @ right to tell pt's son what MD had had a little later to inform of was talking with son's called, et stated that pt's ready told her. Writer then is med's [medications], et if the med's. that the pt. was	G	107			

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		15K015	B. WIN			C 01/06/2012		
	OVIDER OR SUPPLIER FRIENDS HOME HEAD	THCARE INC	•	3	REET ADDRESS, CITY, STATE, ZIP CODE 26 E S MAIN ST GAS CITY, IN 46933		-	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OF	ID PREF TAG		ION LD BE DPRIATE	(X5) COMPLETION DATE			
G 107	message for MD abfrom MD has been resaw pt., et pt is exact Assessment comples she wanted to go to on it for a few second Writer still waited to do with pt." C. A untimed Comprehensive Assevidenced Employer an assessment of the patient's blood some D. The "Faithfut Home Health Aide" (Employee A) went at 1 PM. An addence was awake and talk E. The "Faithfut Home Health Aide" (Employee A) went to get the patient was sleep the dry. Be back at 8 Post of the patient was sleep the dry. Be back at 8 Post of the patient was sleep the dry. Be back at 8 Post of the patient was sleep the dry. Be back at 8 Post of the patient was sleep the dry. The aide left at that states, "11-1-11 multiple times to was succeed. did check	lled MD office back et left but this finding. No call-back eceived @ this time. Writer citly how HHA described. ted. When writer asked pt. if hospital, pt appeared to think ds, then shook her head no. see what pt's son decides to change in Condition Oasis essment dated 11/1/11 e T, a Registered Nurse, did e patient but did not check ugar level. Il Friends Home Healthcare sheet evidenced the HHA to the home again on 11/1/11 dum note indicated the patient ing with the son. Il Friends Home Healthcare sheet evidenced the HHA to the home on 11/1/11 at 5 eleft for the son states, ere 11-1-11 5 PM till 6 PM. e whole hour. Patient was	G	107				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING			C		
		15K015	B. WIN	G		01/0	6/2012
	OVIDER OR SUPPLIER FRIENDS HOME HEALT	THCARE INC		32	EET ADDRESS, CITY, STATE, ZIP CODE 26 E S MAIN ST 6AS CITY, IN 46933		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROVIDENCE)		LD BE	(X5) COMPLETION DATE
G 107	around 9:15 PM and ambulance report sta checked at 13 mg/dl. H. Hospital docu	n wake Patient then!" ily member arrived at home called the ambulance. The tes, "Patient's blood sugar	G	107			
G 111	RECORDS	NTIALITY OF MEDICAL ght to confidentiality of the	G	111			1/16/12
	Based on clinical rec document review and to ensure the confide	I interview, the agency failed ntiality of the patients' n 10 of 10 clinical records					
	Privacy Practices, Eff states, "This notice do information about you and how you ca get a Please review it caref Communications We medical information to about a product or se	u may be used and disclosed access to this information. fully Marketing may use and disclose your communicate with you ervice, to encourage you to or service Fund Raising					

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		15K015	B. WIN				C 6/2012
	OVIDER OR SUPPLIER	HCARE INC	•	3	REET ADDRESS, CITY, STATE, ZIP CODE 126 E S MAIN ST BAS CITY, IN 46933		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX (EACH		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	HOULD BE COMPLET	
G 111	agency. We may disk information to a busin Friends Home Health foundation related to associate or foundation money for the benefit release demographic name and address, a treatment or services want FFHHC or its fo fundraising, you mus St. Gas City,IN 4699 Directory We may inclocation in our facility, general terms, and you directory while you are you do not want inclusor you want to restrict in the directory, you may our objection." 2. Clinical record 1 - patient's rights and rethe day of the patient the above statement. 3. On 1/5/12 at 10 Al indicated the patient of fundraising or the direct admission packet and upon admission of third. 4. On January 7, 2010 Nursing indicated she	tyou to raise funds for this close your medical less associate of Faithful care (FFHHC) or a FFHHC so that business on may contact you to raise of FFHHC. We will only information, such as your and the dates you received from FFHHC. If you do not undation to contact you for t notify: FFHHC 326 E Main 3 in writing. FFHHC lude your name, your your condition described in our religious affiliation in our e a client in our facility If ded in our facility directory, at the information we include must notify, FFHHC of 10 evidences a signed asponsibilities form dated on a sadmission which included M, confidential interview # 1 was unaware of the ectory clause in the dated not been informed as clause.	G	111			
G 121	in the admission pack	et. ICE W/ ACCEPTED	G	121			1/16/12

	(X3) DATE SURVEY COMPLETED	
15K015 B. WING C	5/2012	
NAME OF PROVIDER OR SUPPLIER FAITHFUL FRIENDS HOME HEALTHCARE INC STREET ADDRESS, CITY, STATE, ZIP CODE 326 E S MAIN ST GAS CITY, IN 46933	72012	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
The HHA and its staff must comply with accepted professional standards and principles that apply to professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Based on observation, the agency failed to ensure the staff followed infection control precautions in 2 of 5 home visits observed with the potential to spread infectious disease to all the agency's patients. (#1 and 2) Findings: 1. During a home visit to patient #1 on January 4, 2012, at 6 PM, the home health aide (HHA) was observed helping the patient into the shower. The HHA had two washcloths, one for the patient and one for the HHA. There were more washcloths available for use. The patient washed the face, upper body, legs and under the abdominal fold, then used the safety bar to stand and used the same washcloth to watch the peri area and around the indwelling catheter. The HHA did not offer a clean washcloth for the peri area. (Clinical record #1 identified the patient had frequent urinary tract infections). After the bath, the HHA escorted the patient to the lift chair in the living room. The aide do not sanitize her hands nor put on clean gloves. She rubbed the patient's finger vigorously and stuck the patient three times before getting a proper amount of blood for the		

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NAME OF PR	OVIDER OR SUPPLIER	15K015		ST	REET ADDRESS, CITY, STATE, ZIP CODE	01/0	6/2012
FAITHFUL	FRIENDS HOME HEALT	HCARE INC		;	326 E S MAIN ST GAS CITY, IN 46933		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		LD BE	(X5) COMPLETION DATE
G 122	2. On January 4, 201 home visit to patient a nurse (LPN) was obsthrough a Monty butte cluttered, had a cat o everywhere. The LPI prepared the medicine with the sterile came from the drawing it into a steril supplies came from the drawing it into a steril supplies came from the drawing it into a steril supplies came from the dresser. The LPN did gloved without sanitize the sterile external can the tube of lubricant of patient was holding the sterile catheter with a removed the left gloveremove the bandage. The LPN without sanitizing his gloves. He inserted the catheter into the blad of the 60 cc syringe word the catheter the particles into the catheter the particles return. He results in the supplies the catheter into the c	ult in the family book but did isor. 2, at 3:10 PM during a #2, the licensed practical erved flushing the bladder on. The house was dor, and hair of the cat N washed his hands and e to flush the bladder by with sterile water and then e 60 cc syringe. The ne top of a very cluttered of not wear gloves. The LPN ing his hands and opened theter kit. The LPN threw onto the dirty carpet. The ne non insertible end of the bare left hand. The LPN et to get an alcohol swab and He then cleaned around N removed the right glove. hands, he donned new he lubricated end of the der. He connected the end with the medicine to the end tient had been holding eatheter. He infused the neter and did this several right yellow fluid with large emoved his gloves and the abdomen without using		121			1/16/12

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WIN				С
		15K015		_		01/0	6/2012
	OVIDER OR SUPPLIER FRIENDS HOME HEALT	HCARE INC			REET ADDRESS, CITY, STATE, ZIP CODE 326 E S MAIN ST GAS CITY, IN 46933		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SI TAG CROSS-REFERENCED TO THE AP DEFICIENCY)		_D BE	(X5) COMPLETION DATE
G 122	Continued From page 9		G	122	2		
	Based on clinical recto patient's child, amb hospital record review determined the agency administrator directed health aide to avert he patients in 1 of 1 recowas patient harm with the agency's patients ensure the skilled nur coordinated their effo communicate in 1 of there was patient harm all the agency's patient. The cumulative effect resulted in the agency requirements of the C 484.14: Organization,	the skilled nurse and home arm to a patient and future rd reviewed in which there is the potential to affect all (See G 133), and failed to se and home health aiderts and continued to I record reviewed in which m with the potential to affect ints (See G 143 and G 144). of these systemic problems y's inability to meet the condition of Participation					
G 133	an Immediate Jeopar jeopardy was identified facility was notified of 01/07/2012 at 6 PM. remained unremoved 484.14(c) ADMINIST	RATOR o may also be the or registered nurse required	G	133	3		1/16/12
G 133	The administrator, whe supervising physician under paragraph (d) of directs the agency's of the supervision	o may also be the	G	133	3		1/16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER FRIENDS HOME HEALT			3	REET ADDRESS, CITY, STATE, ZIP CODE 126 E S MAIN ST GAS CITY, IN 46933	0170	10/2012	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTIC TAG CROSS-REFERENCED TO TH DEFICIENCY		TION SHOULD BE COMPL THE APPROPRIATE DA		
G 133	'	e 10 personnel, and the staff.	G	133				
	Based on clinical rec to patient's child, amb hospital record review administrator failed to home health aide to a future patients in 1 of	o direct the skilled nurse and avert harm to a patient and 1 record reviewed in which m with the potential to affect						
	the patient's family m home health aide (HH addendum is several what she felt happen the agency felt what I conclusion was "We on egligent. We do fee obligation as they had log failed to show a real 2. Clinical record # 1 included a plan of cal nursing (SN) 1-2 days 60 days and HHA 5-7 visit 3-5 visits a day.	filed on 11/2/11 at 10 AM by ember's friend saying the HA) was negligent. The pages of the aide sharing ed and two pages of what nappened. The final do not feel our aide was el family failed to met their d promised." The complaint esolution to the complaint. 10, start of care 10/26/11, re with orders for skilled as a week, 1-2 hours a visit x of days a week 1-3 hours a The patient was diabetic ained an order for the SN to						

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	ROVIDER OR SUPPLIER	THCARE INC	•	32	EET ADDRESS, CITY, STATE, ZIP CODE 26 E S MAIN ST AS CITY, IN 46933	,		
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G 133	A. The "Faithful Home Health Aide" si (Employee A) went to AM. The HHA note of different than the present B. An untimed in signed by SN, Emploinformed writer that profused, slurring he [right] side, so much cup or fork. Writer ca [and] son's girlfriend's the pt. did want to die would leave it up to the take pt. to hospital, of stated the only thing comfortable. HHA also brown urine et has an informed MD of this to other than to tell son contacted son's girlfried when writer said. Writer called H MD decision, et HHA girlfriend when writer son's girlfriend had alstarted looking @ pt's discovered that one con could cause a strong the store that the contact of t	Friends Home Healthcare neet evidenced the HHA of the home on 11/1/11 at 8 loes not indicate care was vious day. urses note dated 11/1/11 yee T, states, "HHA t. [patient] is extremely rewords, et very weak on R so that she cannot hold her alled MD [medical doctor] et so cell phone. MD stated that the @ [at] home, et that the MD ne son as to if he wanted to relet pt. die @ home. MD staff can do is to keep her so told writer that the pt. had nodor, et writer also oo. MD gave no orders, what MD said. When writer end, she stated she was she was shopping @ right to tell pt's son what MD had HA a little later to inform of was talking with son's called, et stated that pt's ready told her. Writer then is med's [medications], et of the med's. that the pt. was	G	133				

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G 133	Writer still waited to s do with pt." C. A untimed Ch Comprehensive Asse evidenced Employee an assessment of the the patient's blood su D. The "Faithful Home Health Aide" sl (Employee A) went to at 1 PM. An addendown was awake and talking E. The "Faithful Home Health Aide" sl (Employee A) went to PM. A note the aide "Employee A was her Patient was sleep the dry. Be back at 8 PM F. The "Faithful Home Health Aide" sl (Employee A) went to PM. The aide left at that states, "11-1-11 multiple times to wak succeed. did check put patient didn't hav 1 AM. Hopefully I can G. Patient's fam around 9:15 PM and	ange in Condition Oasis ssment dated 11/1/11 T, a Registered Nurse, did patient but did not check gar level. Friends Home Healthcare neet evidenced the HHA the home again on 11/1/11 am note indicated the patient g with the son. Friends Home Healthcare neet evidenced the HHA the home on 11/1/11 at 5 left for the son states, e 11-1-11 5 PM till 6 PM. whole hour. Patient was I." Friends Home Healthcare neet evidenced the HHA the home on 11/1/11 at 5 left for the son states, e 11-1-11 5 PM till 6 PM. whole hour. Patient was I." Friends Home Healthcare neet evidenced the HHA the home on 11/1/11 at 8 note for the family member was here @ 8 PM. Tried the patient up. Didn't patient's brief. Patient dry. The patient was Patient then!" illy member arrived at home called the ambulance. The tes, "Patient's blood sugar	G	133			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		CONSTRUCTION	(X3) DATE SU COMPLET	ED
		15K015	B. WIN	G			C 6/ 2012
	ROVIDER OR SUPPLIER	THCARE INC	I	326 E	ADDRESS, CITY, STATE, ZIP CODE S MAIN ST CITY, IN 46933	, 0170	0/2012
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G 133	H. Hospital doci room states, "Comate prolonged hypoglyce	uments from the emergency ose felt to be secondary to mic event."		133			1/16/12
	All personnel furnishi to ensure that their e	ing services maintain liaison fforts are coordinated ort the objectives outlined in					
	Based on clinical red child, ambulance run review and interview the skilled nurse and coordinated their effo communicate in 1 of	orts and continued to 1 record reviewed in which rm with the potential to affect					
	included a plan of ca nursing (SN) 1-2 day 60 days and HHA 5-7 visit 3-5 visits a day. The plan of care commonitor and assist w 2. The "Faithful Fried Health Aide" sheet ev A) went to the home	nds Home Healthcare Home videnced the HHA (Employee on 11/1/11 at 8 AM. The ndicate care was different					

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	OVIDER OR SUPPLIER	HCARE INC	•	32	EET ADDRESS, CITY, STATE, ZIP CODE 26 E S MAIN ST GAS CITY, IN 46933		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
G 143	by SN, Employee T, sthat pt. [patient] is exiher words, et very we much so that she can Writer called MD [me girlfriend's cell phone want to die @ [at] holeave it up to the son to hospital, or let pt. conly thing staff can do HHA also told writer tet has an odor, et writoo. MD gave no ord what MD said. When girlfriend, she stated that she was shoppin leaving to tell pt's sor called HHA a little late et HHA was talking wwriter called, et statechad already told her. @ pt's med's [medicaone of the med's. that a stroke in elderly pt's called MD office back about this finding. No been received @ this exactly how HHA descompleted. When write go to hospital, pt a few seconds, then she waited to see what pt 4. A untimed Change Comprehensive Asseevidenced Employee	s note dated 11/1/11 signed states, "HHA informed writer tremely confused, slurring tak on R [right] side, so not hold her cup or fork. dical doctor] et [and] son's. MD stated that the pt. did me, et that the MD would as to if he wanted to take pt. lie @ home. MD stated the o is to keep her comfortable. That the pt. had brown urine ter also informed MD of this ers, other than to tell son writer contacted son's she was leaving the store g @ right then, et was a what MD had said. Writer er to inform of MD decision, ith son's girlfriend when d that pt's son's girlfriend when d that pt's son's girlfriend writer then started looking tions], et discovered that the pt. was on could cause is with dementia. Writer et et left message for MD to call-back from MD has time. Writer saw pt., et pt is cribed. Assessment iter asked pt. if she wanted oppeared to think on it for a ook her head no. Writer still 's son decides to do with pt."	G	143			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		15K015	B. WIN				C
	OVIDER OR SUPPLIER FRIENDS HOME HEALT			3	REET ADDRESS, CITY, STATE, ZIP CODE B26 E S MAIN ST GAS CITY, IN 46933	1 01/0	6/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 143	Health Aide" sheet ev A) went to the home a An addendum note in awake and talking wit 6. The "Faithful Friend Health Aide" sheet ev A) went to the home of the aide left for the so here 11-1-11 5 PM till the whole hour. Paties PM." 7. The "Faithful Friend Health Aide" sheet ev A) went to the home of aide left a note for the "11-1-11 was here @ to wake patient up. Expatient's brief. Patienthave PM med's. Will I can wake Patient the 8. Patient's family mearound 9:15 PM and ambulance report starchecked at 13 mg/dl." 9. Hospital document states, "Comatose fel prolonged hypoglycer"	ds Home Healthcare Home idenced the HHA (Employee again on 11/1/11 at 1 PM. dicated the patient was high the son. ds Home Healthcare Home idenced the HHA (Employee on 11/1/11 at 5 PM. A note on states, "Employee A was 6 PM. Patient was sleep ent was dry. Be back at 8 ds Home Healthcare Home idenced the HHA (Employee on 11/1/11 at 8 PM. The family member that states, 8 PM. Tried multiple times bidn't succeed. did check at dry. But patient didn't be back at 1 AM. Hopefully en!" ember arrived at home called the ambulance. The tes, "Patient's blood sugar at the form the emergency room to be secondary to mic event."		143			
G 144	484.14(g) COORDINA SERVICES The clinical record or		G	144			1/16/12

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION	(X3) DATE SUR COMPLETI	ED
		15K015	B. WIN	G			C 6/2012
	OVIDER OR SUPPLIER	HCARE INC	.	3:	REET ADDRESS, CITY, STATE, ZIP CODE 26 E S MAIN ST GAS CITY, IN 46933	,	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 144	reporting, and coordinoccur. This STANDARD is a Based on clinical recommendation.	n that effective interchange, nation of patient care does not met as evidenced by: ord, aide note to patient's	G	144			
	review and interview, the skilled nurse and coordinated their effo communicate in 1 of there was patient har all the agency's patie	rts and continued to 1 record reviewed in which m with the potential to affect					
	included a plan of car nursing (SN) 1-2 days 60 days and HHA 5-7 visit 3-5 visits a day. The plan of care cont monitor and assist wi 2. The "Faithful Frier Health Aide" sheet ev A) went to the home of HHA note does not in than the previous day 3. An untimed nurses by SN, Employee T, s that pt. [patient] is ext her words, et very we much so that she can	nds Home Healthcare Home ridenced the HHA (Employee on 11/1/11 at 8 AM. The dicate care was different					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K015	A. BUIL				C 6/2012
	ROVIDER OR SUPPLIER	I		326	ET ADDRESS, CITY, STATE, ZIP CODE E S MAIN ST S CITY, IN 46933	1 01700	6/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 144	want to die @ [at] ho leave it up to the son to hospital, or let pt. conly thing staff can de HHA also told writer the thas an odor, et writer too. MD gave no ord what MD said. Where girlfriend, she stated that she was shoppin leaving to tell pt's sor called HHA a little late the HHA was talking writer called, et state had already told her. @ pt's med's [medicatione of the med's. that a stroke in elderly pt's called MD office back about this finding. No been received @ this exactly how HHA descompleted. When write go to hospital, pt a few seconds, then she waited to see what pt 4. A untimed Change Comprehensive Asse evidenced Employee an assessment of the the patient's blood sufficients.	me, et that the MD would as to if he wanted to take pt. die @ home. MD stated the to is to keep her comfortable. hat the pt. had brown urine ter also informed MD of this ers, other than to tell son in writer contacted son's she was leaving the store in what MD had said. Writer er to inform of MD decision, with son's girlfriend when in that pt's son's girlfriend when in the pt. was on could cause in what MD had said. Writer then started looking ations], et discovered that it the pt. was on could cause is with dementia. Writer it the pt. was on could cause is with dementia. Writer it is et left message for MD in call-back from MD has in time. Writer saw pt., et pt is scribed. Assessment iter asked pt. if she wanted ppeared to think on it for a look her head no. Writer still its son decides to do with pt." The in Condition Oasis is in Condition Oasis is sement dated 11/1/11 The Registered Nurse, did is patient but did not check	G	144			

	OF DEFICIENCIES CORRECTION					
			A. BUILI			c
		15K015	B. WING	S	01/0	06/2012
	OVIDER OR SUPPLIER FRIENDS HOME HEALT	HCARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 326 E S MAIN ST GAS CITY, IN 46933		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 144	awake and talking with 6. The "Faithful Friend Health Aide" sheet even A) went to the home of the aide left for the schere 11-1-11 5 PM till the whole hour. Paties PM." 7. The "Faithful Friend Health Aide" sheet even A) went to the home of aide left a note for the "11-1-11 was here @		G 1	44		
G 156	patient's brief. Patien have PM med's. Will I can wake Patient the 8. Patient's family me around 9:15 PM and ambulance report statchecked at 13 mg/dl.' 9. Hospital document states, "Comatose fel prolonged hypoglycer 484.18 ACCEPTANC MED SUPER This CONDITION is Based on clinical recibild, ambulance run	at dry. But patient didn't be back at 1 AM. Hopefully en!" ember arrived at home called the ambulance. The tes, "Patient's blood sugar ts from the emergency room t to be secondary to	G 1	56		1/16/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WIN				С
		15K015				01/0	6/2012
	OVIDER OR SUPPLIER FRIENDS HOME HEALT	HCARE INC		32	EET ADDRESS, CITY, STATE, ZIP CODE 16 E S MAIN ST AS CITY, IN 46933		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
G 156	agency failed to ensure adequately met in the reviewed with patient potential to affect all the 157), failed to ensure visits as ordered on the clinical records review affect all the agency's failed to ensure the platient was to have "of those comfort measure reviewed of patients with the potential to affect (See G 159).	re the patient's needs were home in 1 of 1 record harm resulting in the he agency's patients (See G the skilled nurse made ne plan of care in 1 of 10 wed with the potential to a patients (See G 158), and an of care identified the comfort measures" and what res were in 1 of 1 record with patient harms resulting act all the agency's patients	G	156			
G 157	resulted in the agency with the Condition of Acceptance of Patien Medical Supervision pagency's 131 patients These finding resulting an Immediate Jeopar jeopardy was identified facility was notified of 01/07/2012 at 6 PM. remained unremoved 484.18 ACCEPTANC MED SUPER Patients are accepted of a reasonable experimedical, nursing, and	ts, Plan of Care, and cotentially affecting all of the s. g in the determination that dy existed. The immediate ed on 01/07/2012. The the Immediate Jeopardy on The Immediate Jeopardy	G	157			1/16/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K015	B. WIN				C 6/ 2012	
	ROVIDER OR SUPPLIER	THCARE INC		326 E	ADDRESS, CITY, STATE, ZIP CODE S MAIN ST CITY, IN 46933	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
G 157	Based on clinical recchild, ambulance run review and interview the patient's needs whome in 1 of 1 record resulting in the potent patients. (#10) Findings: 1. Clinical record #1 included a plan of canursing (SN) 1-2 day 60 days and HHA 5-visit 3-5 visits a day. The plan of care commonitor and assist w 2. The "Faithful Fried Health Aide" sheet end and the previous day. The plan of care commonitor and assist with a mote does not in than the previous day. 3. An untimed nurse by SN, Employee T, that pt. [patient] is experimentally in the previous day. The plan of care con monitor and assist with a mote does not in than the previous day. The plan of care to hospital, every we much so that she can writer called MD [megirlfriend's cell phone want to die @ [at] holeave it up to the son to hospital, or let pt. conly thing staff can deliance in the previous day.	not met as evidenced by: cord, aide note to patient's record, and hospital record the agency failed to ensure were adequately met in the direviewed with patient harm tial to affect all the agency's 10, start of care 10/26/11, re with orders for skilled s a week, 1-2 hours a visit x days a week 1-3 hours a The patient was diabetic tained an order for the SN to ith accuchecks PRN. Indis Home Healthcare Home widenced the HHA (Employee on 11/1/11 at 8 AM. The indicate care was different	G	157				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	ED
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	ROVIDER OR SUPPLIER FRIENDS HOME HEALT	THCARE INC	<u> </u>	3:	REET ADDRESS, CITY, STATE, ZIP CODE 26 E S MAIN ST GAS CITY, IN 46933	01700	0/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
G 157	what MD said. When girlfriend, she stated that she was shoppin leaving to tell pt's sor called HHA a little late et HHA was talking w writer called, et stated had already told her. @ pt's med's [medica one of the med's. tha a stroke in elderly pt's called MD office back about this finding. No been received @ this exactly how HHA des completed. When wr to go to hospital, pt a few seconds, then sh waited to see what pt 4. A untimed Change Comprehensive Asse evidenced Employee an assessment of the the patient's blood su 5. The "Faithful Frier Health Aide" sheet ev A) went to the home and addendum note in awake and talking with the left for the sor the aide left for the sor the aide left for the sor called the state of the sor the aide left for the sor called the state of the sta	ers, other than to tell son writer contacted son's she was leaving the store g@right then, et was what MD had said. Writer er to inform of MD decision, ith son's girlfriend when d that pt's son's girlfriend Writer then started looking tions], et discovered that t the pt. was on could cause s with dementia. Writer et eleft message for MD o call-back from MD has time. Writer saw pt., et pt is cribed. Assessment iter asked pt. if she wanted ppeared to think on it for a ook her head no. Writer still 's son decides to do with pt." et in Condition Oasis ssment dated 11/1/11 T, a Registered Nurse, did e patient but did not check gar level. ands Home Healthcare Home widenced the HHA (Employee again on 11/1/11 at 1 PM. dicated the patient was	G	157			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	FIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		15K015	B. WING			6/2012
	ROVIDER OR SUPPLIER	THCARE INC	s	TREET ADDRESS, CITY, STATE, ZIP CODE 326 E S MAIN ST GAS CITY, IN 46933		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 158	PM." 7. The "Faithful Frier Health Aide" sheet ex A) went to the home aide left a note for the "11-1-11 was here @ to wake patient up. I patient's brief. Patier have PM med's. Will I can wake Patient th 8. Patient's family maround 9:15 PM and ambulance report stachecked at 13 mg/dl. 9. Hospital document states, "Comatose fe prolonged hypoglyce 484.18 ACCEPTANOMED SUPER Care follows a writter and periodically revieosteopathy, or podiate to state and periodically revieosteopathy, or podiate to ensure the sordered on the plant of the state and periodical plant of the pl	ands Home Healthcare Home videnced the HHA (Employee on 11/1/11 at 8 PM. The efamily member that states, 8 PM. Tried multiple times Didn't succeed. did check of dry. But patient didn't be back at 1 AM. Hopefully en!" The ember arrived at home called the ambulance. The tes, "Patient's blood sugar" The ts from the emergency room let to be secondary to mic event." The EOF PATIENTS, POC, The plan of care established awed by a doctor of medicine, ric medicine. The test as evidenced by: The cord review, the agency killed nurse made visits as of care in 1 of 10 clinical in the potential to affect all	G 15			1/16/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER	15K015		STDE	EET ADDRESS, CITY, STATE, ZIP CODE	01/0	6/2012
	FRIENDS HOME HEALT	HCARE INC		32	6 E S MAIN ST AS CITY, IN 46933		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 158	included a plan of car nursing (SN) 1-2 days for 60 days and home a week 1-3 hours a vicertification period 10 patient is diabetic. The assist with accucheck 2. The clinical record skilled nurse made a second week when the speech. This was a formal states, "Start SN servent 1-2 hours/visit. Chann to 10/31/11 to 12/29/10 order dated 1/2/11 states the first week of admit of range." 484.18(a) PLAN OF (Construction of the agency staff cover including mental state equipment required, for prognosis, rehabilitatic limitations, activities prequirements, medical safety measures to prognosi the state of the agency staff of timely any other appropriate. This STANDARD is repaid to the state of t	O, start of care 10/26/11, re with orders for skilled a week, 1-2 hours a visit re health aide (HHA) 5-7 days sit 3-5 visits a day for the re SN may monitor and as PRN. failed to evidence the visit until the 3rd day of the re patient was having slurred PRN (if needed) visit. one order dated 10/31/11 rices today, 1-2 day/week, ge plan of care recert period 11." A physician telephone rates, "SN did not do services assion, putting frequency out CARE eloped in consultation with res all pertinent diagnoses, as, types of services and requency of visits, on potential, functional permitted, nutritional retions and treatments, any rotect against injury, discharge or referral, and		158			1/16/12

	OF DEFICIENCIES CORRECTION						
		15K015		G			C 06/2012
	OVIDER OR SUPPLIER	THCARE INC	•	326	ET ADDRESS, CITY, STATE, ZIP CODE SES MAIN ST SCITY, IN 46933		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
G 159	measures" and what were in 1 of 1 record patient harms result the agency's patient. Findings: 1. On 01-06-12 at 2 health aide (HHA), in home to patient #10 the patient. She the patient for incontinet turned the patient with awakening. She then where she placed the the refrigerator and is She then left the patient was breathing. She then left the patient had noted the put was breathing. Shome. Upon further had not contacted he when she was unab indicated the supervicase was for comfort employee A was ask were in place she with question as she stat not been told. 2. The plan of care	was to have "comfort t those comfort measures I reviewed of patients with ng in the potential to affect all	G	159			
	indicate any type of measures. 3. On 01-06-12 at 3	ere in place nor did the POC parameters for comfort :10 PM, employee U, the ndicated that the patient was					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′	LTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILD			С
		15K015	B. WING	i	01/0	06/2012
	ROVIDER OR SUPPLIER I FRIENDS HOME HEALT	THCARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 326 E S MAIN ST GAS CITY, IN 46933		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 159 G 168	measures were need this was not documer patient's record. The	indicated that comfort ed. Employee U indicated nted anywhere in the agency did not have a n place on what comfort collowed or practiced.	G 1			1/16/12
	Based on clinical recibild, ambulance run review and interview, agency failed to ensure visits as ordered on the clinical records review affect all the agency's agency failed to ensure evaluated the patient patient had a change record reviewed of patient harm with the agency's patients (Set the registered nurse of when the patient had 1 patient record reviewed experienced patient haffect all the agency's failed to ensure the saide coordinated their communicate in 1 of there was patient har all the agency's patient.	narm with the potential to a patients (See G 174), and willed nurse and home health or efforts and continued to 1 record reviewed in which m with the potential to affect				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		CONSTRUCTION	(X3) DATE SU COMPLE	TED
		15K015	B. WIN	G		01/0	C 06/2012
	OVIDER OR SUPPLIER FRIENDS HOME HEAL	THCARE INC	I	326 E	ADDRESS, CITY, STATE, ZIP CODE S MAIN ST CITY, IN 46933	1 0170	70/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
G 168	Continued From page Nurse Services poter patients of the agence	ntiality affecting all 131	G	168			
G 170	an Immediate Jeopar jeopardy was identified facility was notified of 01/07/2012 at 6 PM. remained unremoved 484.30 SKILLED NU	RSING SERVICES	G	170			1/16/12
	Based on clinical red failed to ensure the s ordered on the plan of	not met as evidenced by: cord review, the agency killed nurse made visits as of care in 1 of 10 clinical in the potential to affect all i. (#10)					
	included a plan of canursing (SN) 1-2 day for 60 days and home a week 1-3 hours a vocrtification period 10 patient is diabetic. The assist with accuched	0, start of care 10/26/11, re with orders for skilled s a week, 1-2 hours a visit e health aide (HHA) 5-7 days isit 3-5 visits a day for the 0/26/11 to 12/24/11. The he SN may monitor and ks PRN.					
	skilled nurse made a	visit until the 3rd day of the ne patient was having slurred					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SUR COMPLETI	
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	OVIDER OR SUPPLIER FRIENDS HOME HEALT	L		32	EET ADDRESS, CITY, STATE, ZIP CODE 26 E S MAIN ST	01/00	6/2012
				G	GAS CITY, IN 46933		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
G 170	Continued From page	27	G	170			
G 172	states, "Start SN serv 1-2 hours/visit. Chan to 10/31/11 to 12/29/1 order dated 1/2/11 sta the first week of admi of range." 484.30(a) DUTIES Of	one order dated 10/31/11 ices today, 1-2 day/week, ge plan of care recert period 11." A physician telephone ates, "SN did not do services ssion, putting frequency out	G	172			1/16/12
	NURSE The registered nurse patients nursing need	regularly re-evaluates the s.					
	Based on clinical rec child, ambulance run review and interview, the registered nurse of sugar when the patien in 1 of 1 patient recor	not met as evidenced by: ord, aide note to patient's record and hospital record the agency failed to ensure evaluated the patient's blood int had a change in condition d reviewed of patients that learm with the potential to s patients. (#10)					
	Findings:						
	included a plan of car nursing (SN) 1-2 days 60 days and HHA 5-7 visit 3-5 visits a day.	10, start of care 10/26/11, re with orders for skilled is a week, 1-2 hours a visit x days a week 1-3 hours a The patient was diabetic ained an order for the SN to th accuchecks PRN.					
	by SN, Employee T, s	s note dated 11/1/11 signed states, "HHA informed writer remely confused, slurring					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	I		326	T ADDRESS, CITY, STATE, ZIP CODE E S MAIN ST S CITY, IN 46933		6/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
G 172	much so that she car Writer called MD [me girlfriend's cell phone want to die @ [at] holeave it up to the son to hospital, or let pt. conly thing staff can de HHA also told writer tet has an odor, et writoo. MD gave no ord what MD said. Wher girlfriend, she stated that she was shoppin leaving to tell pt's sor called HHA a little lattet HHA was talking wwriter called, et state had already told her. @ pt's med's [medica one of the med's. that a stroke in elderly pt's called MD office back about this finding. No been received @ this exactly how HHA descompleted. When write go to hospital, pt a few seconds, then she waited to see what pto the patient's blood suffice product the product	eak on R [right] side, so anot hold her cup or fork. dical doctor] et [and] son's. MD stated that the pt. did me, et that the MD would as to if he wanted to take pt. die @ home. MD stated the pt. die @ home. MD stated the pt. hat the pt. had brown urine ter also informed MD of this ers, other than to tell son a writer contacted son's she was leaving the store g @ right then, et was a what MD had said. Writer er to inform of MD decision, with son's girlfriend when de that pt's son's girlfriend when de the pt. was on could cause as with dementia. Writer the pt. was on could cause as with dementia and the pt. was on could cause as with dementia and the pt. was on could cause as with dementia and the pt. was on could cause as with dementia and the pt. was on could cause as with dementia and the pt. was on could cause as with dementia and the pt. was on could cause as with dementia and the pt. was on could cause as with the pt. was on could ca	G	172			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
						С
		15K015	B. WING		01/0	6/2012
	OVIDER OR SUPPLIER FRIENDS HOME HEALT	HCARE INC	;	STREET ADDRESS, CITY, STATE, ZIP CODE 326 E S MAIN ST GAS CITY, IN 46933		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPRO	ULD BE	(X5) COMPLETION DATE
G 172	Health Aide" sheet ev A) went to the home a An addendum note in awake and talking wit	idenced the HHA (Employee again on 11/1/11 at 1 PM. dicated the patient was h the son.	G 1	72		
	Health Aide" sheet ev A) went to the home of the aide left for the so here 11-1-11 5 PM till	ds Home Healthcare Home idenced the HHA (Employee on 11/1/11 at 5 PM. A note on states, "Employee A was 6 PM. Patient was sleep ent was dry. Be back at 8				
	Health Aide" sheet ev A) went to the home of aide left a note for the "11-1-11 was here @ to wake patient up. D patient's brief. Patien	ds Home Healthcare Home idenced the HHA (Employee on 11/1/11 at 8 PM. The family member that states, 8 PM. Tried multiple times bidn't succeed. did check it dry. But patient didn't be back at 1 AM. Hopefully en!"				
	around 9:15 PM and	ember arrived at home called the ambulance. The tes, "Patient's blood sugar				
G 174	8. Hospital document states, "Comatose fel prolonged hypoglycer 484.30(a) DUTIES OI NURSE	nic event."	G 1	74		1/16/12
	_	furnishes those services and specialized nursing skill.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	JLTIPLE CONSTRUCTION		(X3) DATE SUR COMPLETE	
		B. WIN			(
	15K015	D. WIIN	<u> </u>		01/06	6/2012
NAME OF PROVIDER OR SUPPLIER FAITHFUL FRIENDS HOME HEALTH	CARE INC		STREET ADDRESS, CITY, STATE 326 E S MAIN ST GAS CITY, IN 46933	E, ZIP CODE		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOUL CED TO THE APPROF EFICIENCY)	.D BE	(X5) COMPLETION DATE
child, ambulance run re review and interview, the registered nurse util when the patient had a 1 patient record reviewed experienced patient har affect all the agency's particular field a plan of care nursing (SN) 1-2 days a 60 days and HHA 5-7 disit 3-5 visits a day. The plan of care contain monitor and assist with 2. An untimed nurses responsible by SN, Employee T, states that pt. [patient] is extres her words, et very weak much so that she cannow Writer called MD [medicing girlfriend's cell phone. It want to die @ [at] home leave it up to the son as to hospital, or let pt. die only thing staff can do is HHA also told writer that et has an odor, et writer too. MD gave no orders what MD said. When we	t met as evidenced by: rd, aide note to patient's ecord and hospital record ne agency failed to ensure lized her nursing skill change in condition in 1 of ed of patients that rm with the potential to patients. (#10) , start of care 10/26/11, with orders for skilled a week, 1-2 hours a visit x lays a week 1-3 hours a he patient was diabetic ned an order for the SN to accuchecks PRN. note dated 11/1/11 signed ates, "HHA informed writer emely confused, slurring k on R [right] side, so ot hold her cup or fork. cal doctor] et [and] son's MD stated that the pt. did e, et that the MD would s to if he wanted to take pt. e @ home. MD stated the s to keep her comfortable. at the pt. had brown urine r also informed MD of this s, other than to tell son writer contacted son's lie was leaving the store	G	174			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		E CONSTRUCTION	(X3) DATE SUF COMPLET	
		15K015	B. WIN				C 6/2012
	OVIDER OR SUPPLIER FRIENDS HOME HEALT	HCARE INC		326	ET ADDRESS, CITY, STATE, ZIP CODE E S MAIN ST IS CITY, IN 46933	,	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
G 174	leaving to tell pt's son called HHA a little late et HHA was talking w writer called, et stated had already told her. @ pt's med's [medica one of the med's. that a stroke in elderly pt's called MD office back about this finding. No been received @ this exactly how HHA des completed. When wr to go to hospital, pt afew seconds, then sh waited to see what pt 3. A untimed Change Comprehensive Asse evidenced Employee an assessment of the the patient's blood su 4. The "Faithful Frier Health Aide" sheet ev A) went to the home a An addendum note in awake and talking with 5. The "Faithful Frier Health Aide" sheet ev A) went to the home of the aide left for the schere 11-1-11 5 PM till the whole hour. Patie PM."	what MD had said. Writer or to inform of MD decision, ith son's girlfriend when dethat pt's son's girlfriend white then started looking tions], et discovered that the pt. was on could cause with dementia. Writer et left message for MD of call-back from MD has time. Writer saw pt., et pt is cribed. Assessment iter asked pt. if she wanted opeared to think on it for a look her head no. Writer still of son decides to do with pt." It in Condition Oasis sament dated 11/1/11 The registered Nurse, did opatient but did not check gar level. Indicated the HHA (Employee again on 11/1/11 at 1 PM. dicated the patient was	G	174			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUII B. WIN				С
		15K015	D. WIIV	<u> </u>		01/0	6/2012
	ROVIDER OR SUPPLIER FRIENDS HOME HEALT	THCARE INC		32	EET ADDRESS, CITY, STATE, ZIP CODE 26 E S MAIN ST 3AS CITY, IN 46933		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 174	Health Aide" sheet ex A) went to the home aide left a note for the "11-1-11 was here @ to wake patient up. It patient's brief. Patier have PM med's. Will I can wake Patient th T. Patient's family maround 9:15 PM and ambulance report statchecked at 13 mg/dl. 8. Hospital document states, "Comatose fe prolonged hypoglyce 484.30(a) DUTIES ONURSE The registered nurse progress notes, coord physician and other patient's condition and This STANDARD is a Based on clinical recibild, ambulance run review and interview, the skilled nurse and coordinated their efforcommunicate in 1 of	videnced the HHA (Employee on 11/1/11 at 8 PM. The er family member that states, 8 PM. Tried multiple times Didn't succeed. did check at dry. But patient didn't be back at 1 AM. Hopefully en!" ember arrived at home called the ambulance. The tes, "Patient's blood sugar" Its from the emergency room let to be secondary to mic event." F THE REGISTERED prepares clinical and dinates services, informs the personnel of changes in the dineeds. Inot met as evidenced by: cord, aide note to patient's record, and hospital record the agency failed to ensure home health aide rts and continued to 1 record reviewed in which m with the potential to affect		174			1/16/12
	Health Aide" sheet ex A) went to the home aide left a note for the "11-1-11 was here @ to wake patient up. It patient's brief. Patier have PM med's. Will I can wake Patient th T. Patient's family maround 9:15 PM and ambulance report statchecked at 13 mg/dl. 8. Hospital document states, "Comatose fe prolonged hypoglyce 484.30(a) DUTIES ONURSE The registered nurse progress notes, coord physician and other patient's condition and This STANDARD is a Based on clinical recibild, ambulance run review and interview, the skilled nurse and coordinated their efforcommunicate in 1 of there was patient har all the agency's patient's patient's patient and the agency's patient was patient har all the agency's patient.	videnced the HHA (Employee on 11/1/11 at 8 PM. The er family member that states, 8 PM. Tried multiple times Didn't succeed. did check at dry. But patient didn't be back at 1 AM. Hopefully en!" ember arrived at home called the ambulance. The tes, "Patient's blood sugar" Its from the emergency room let to be secondary to mic event." F THE REGISTERED prepares clinical and dinates services, informs the personnel of changes in the dineeds. Inot met as evidenced by: cord, aide note to patient's record, and hospital record the agency failed to ensure home health aide rts and continued to 1 record reviewed in which m with the potential to affect					1/16/

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		E CONSTRUCTION	(X3) DATE SUR COMPLETE	ED
		15K015	B. WIN	G			C 6/2012
	ROVIDER OR SUPPLIER	THCARE INC		326	EET ADDRESS, CITY, STATE, ZIP CODE 6 E S MAIN ST AS CITY, IN 46933	01700	0/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
G 176	1. Clinical record # 1 included a plan of ca nursing (SN) 1-2 day 60 days and HHA 5-7 visit 3-5 visits a day. The plan of care contimonitor and assist with 2. The "Faithful Friet Health Aide" sheet eval went to the home HHA note does not in than the previous day 3. An untimed nurse by SN, Employee T, that pt. [patient] is exher words, et very we much so that she car Writer called MD [me girlfriend's cell phone want to die @ [at] ho leave it up to the son to hospital, or let pt. conly thing staff can de that also told writer that an odor, et writer too. MD gave no ord what MD said. Where girlfriend, she stated that she was shoppin leaving to tell pt's sor called HHA a little late that already told her. @ pt's med's [medical care in the care	0, start of care 10/26/11, re with orders for skilled s a week, 1-2 hours a visit x days a week 1-3 hours a The patient was diabetic tained an order for the SN to th accuchecks PRN. The hods Home Healthcare Home widenced the HHA (Employee on 11/1/11 at 8 AM. The indicate care was different	G	176			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	ED
		15K015	B. WIN	IG			C 6/2012
	ROVIDER OR SUPPLIER	THCARE INC		3	REET ADDRESS, CITY, STATE, ZIP CODE 126 E S MAIN ST GAS CITY, IN 46933		0/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
G 176	a stroke in elderly pt's called MD office back about this finding. No been received @ this exactly how HHA descompleted. When wr to go to hospital, pt a few seconds, then sh waited to see what pt 4. A untimed Change Comprehensive Asse evidenced Employee an assessment of the the patient's blood su 5. The "Faithful Frier Health Aide" sheet ev A) went to the home and addendum note in awake and talking with 6. The "Faithful Frier Health Aide" sheet ev A) went to the home of the aide left for the schere 11-1-11 5 PM till the whole hour. Patien PM." 7. The "Faithful Frier Health Aide" sheet ev A) went to the home of the aide left a note for th	s with dementia. Writer tet left message for MD to call-back from MD has time. Writer saw pt., et pt is cribed. Assessment iter asked pt. if she wanted ppeared to think on it for a ook her head no. Writer still 's son decides to do with pt." e in Condition Oasis ssment dated 11/1/11 T, a Registered Nurse, did patient but did not check gar level. ads Home Healthcare Home ridenced the HHA (Employee again on 11/1/11 at 1 PM. dicated the patient was	G	176			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		15K015	B. WIN				C
	ROVIDER OR SUPPLIER FRIENDS HOME HEALT			32	REET ADDRESS, CITY, STATE, ZIP CODE 126 E S MAIN ST GAS CITY, IN 46933	01/06	6/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
G 176	I can wake Patient the 8. Patient's family me around 9:15 PM and ambulance report starchecked at 13 mg/dl." 9. Hospital document states, "Comatose fel prolonged hypoglycer 484.36 HOME HEALT This CONDITION is Based on policy and health aide job descriptive, observation, a determined the agency health aide was assig registered nurse for 6 services from home health aide was assig registered nurse for 6 services from home health aide instructions were nurse for 6 of 10 clien home health agency of services from home health agency of harm or imminent receiving home health agency of harm or imminent receiving home health aides revided services accument to the provided services accum	ember arrived at home called the ambulance. The tes, "Patient's blood sugar as from the emergency room to be secondary to mic event." TH AIDE SERVICES The test of the emergency room to be secondary to mic event." TH AIDE SERVICES The test of the emergency room to be secondary to mic event." TH AIDE SERVICES The test of the		202			1/16/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			(X3) DATE SUF COMPLET	
		15K015	B. WIN			01/06	
NAME OF PROVIDER OR SUPPLIER FAITHFUL FRIENDS HOME HEALTHCARE INC		I		326	EET ADDRESS, CITY, STATE, ZIP CODE 6 E S MAIN ST	01/0	6/2012
			GA	AS CITY, IN 46933		I	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 202	resulted in the agence with the Condition of Health Aide Services These finding resultir an Immediate Jeopar jeopardy was identified facility was notified or 01/07/2012 at 6 PM. remained unremoved 484.36(c)(1) ASSIGN HOME HEALTH AIDED The home health aided patient by the register. This STANDARD is a Based on clinical redialed to ensure the health assigned to patients 1, 4, 5, 6, 7, and 10) services from home health aided to patients receiving home the potential for harm patients receiving home. The findings include: 1. Clinical record 1, sincluded a plan of call health aide services of period 11/18/11 to 1/1 record failed to evide health aide assignments.	to of these systemic problems by being out of compliance Participation 484.36: Home ag in the determination that dy existed. The immediate ed on 01/07/2012. The fithe Immediate Jeopardy on The Immediate Jeopardy I at the survey exit. IMENT & DUTIES OF a is assigned to a specific ared nurse. The immediate Jeopardy I at the survey exit. IMENT & DUTIES OF a is assigned to a specific ared nurse. The immediate Jeopardy I at the survey exit. IMENT & DUTIES OF a is assigned to a specific ared nurse. The immediate Jeopardy I at the survey exit. IMENT & DUTIES OF a is assigned to a specific ared nurse. The immediate Jeopardy I at the survey exit. IMENT & DUTIES OF a is assigned to a specific ared nurse. The immediate Jeopardy I at the survey exit. IMENT & DUTIES OF a is assigned to a specific ared nurse. The immediate Jeopardy I at the survey exit. IMENT & DUTIES OF a is assigned to a specific ared nurse. The immediate Jeopardy I at the survey exit. IMENT & DUTIES OF a is assigned to a specific ared nurse. The immediate Jeopardy I at the survey exit. IMENT & DUTIES OF a is assigned by a feet of the survey exit. IMENT & DUTIES OF a is assigned by the The immediate Jeopardy I at the survey exit. IMENT & DUTIES OF a is assigned by the The immediate Jeopardy I at the survey exit. IMENT & DUTIES OF a is assigned to a specific ared nurse.		202	DEFICIENCY)		1/16/12
	registered nurse (RN 2. Clinical record 4, 9). SOC 9/24/11, included a plan					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		15K015	B. WIN			C 01/06/2		
	OVIDER OR SUPPLIER FRIENDS HOME HEALT			3:	REET ADDRESS, CITY, STATE, ZIP CODE 26 E S MAIN ST GAS CITY, IN 46933	01/0	6/2012	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
G 223	of care with orders for certification period 9/r clinical record failed to home health aide ass RN. 3. Clinical record 5, S of care with orders for certification period 10 clinical record failed to home health aide ass RN. 4. Clinical record 6, S plan of care with order certification period 9/r record failed to evide health aide assignments. 5. Clinical record 7, S of care with orders for certification period 10 clinical record failed to home health aide assignments.	e 37 THHA services for the 14/11 to 11/23/11. The covidence a current signed ignment sheet signed by the SOC 1/21/11, included a plan of HHA services for the 1/16/11 to 12/14/11. The covidence a current signed ignment sheet signed by the SOC 11/30/10, included a plan of HHA services for the 1/26/11-11/24/11. The clinical of the 1/26/11-11/24/11. The clinical of the 1/26/11, included a plan of HHA services for the 1/26/11. The covidence a current signed by the 1/26/11. The covidence a current signed ignment sheet signed by the 1/26/11. The covidence a current signed ignment sheet signed by the 1/26/11, included a plan of the 1/26/11, included a 1/26/11, included	G	223				
G 224	plan of care with order certification period 10 clinical record failed to home health aide assecompleted and signed	rs for HHA services for the /26/11 to 12/24/11. The o evidence a current signed ignment sheet had been to by the RN. MENT & DUTIES OF	G	224			1/16/12	
	health aide must be p	nstructions for the home repared by the registered riate professional who is						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		15K015	B. WIN				C 6/ 2012	
NAME OF PROVIDER OR SUPPLIER FAITHFUL FRIENDS HOME HEALTHCARE INC		'	32	EET ADDRESS, CITY, STATE, ZIP CODE 26 E S MAIN ST 6AS CITY, IN 46933				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
G 224	This STANDARD is a Based on clinical record failed to ensure the howere prepared by the 4, 5, 6, 7, and 10) of from home health agrotential for harm or patients receiving how the findings include: 1. Clinical record 1, sincluded a plan of calculated a plan of calculated a plan of calculated to evide health aide assignment registered nurse (RN 2. Clinical record 4, so ficare with orders for certification period 9/clinical record failed to home health aide assignment assignment and the second side of th	agraph (d) of this section. The	G	2224				
	clinical record failed thome health aide ass	o evidence a current signed signment sheet signed by the SOC 11/30/10, included a						

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUFPLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING						
		15K015	B. WIN				C C/2012
NAME OF PROVIDER OR SUPPLIER FAITHFUL FRIENDS HOME HEALTHCARE INC			I	3	REET ADDRESS, CITY, STATE, ZIP CODE 126 E S MAIN ST GAS CITY, IN 46933	01700	6/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE ISS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
G 224	certification period 9/2 record failed to evider health aide assignme 5. Clinical record 7, S of care with orders for certification period 10 clinical record failed to home health aide ass RN. 6. Clinical record 10, plan of care with order certification period 10 clinical record failed to home health aide ass completed and signed 484.36(c)(2) ASSIGN HOME HEALTH AIDE. The home health aide ordered by the physic that the aide is permit law. This STANDARD is real based on policy and health aide job descripeview, observation, a failed to ensure the his services according to ordered by the physic ordered by the physical condendation of the physical certification period 10 clinical record failed to ensure the his services according to ordered by the physical certification period 10 clinical record failed to ensure the his services according to ordered by the physical certification period 10 clinical record failed to ensure the his services according to ordered by the physical certification period 10 clinical record failed to ensure the his services according to ordered by the physical certification period 10 clinical record failed to ensure the his services according to ordered by the physical certification period 10 clinical record failed to ensure the his services according to ordered by the physical certification period 10 clinical record failed to ensure the his services according to ordered by the physical certification period 10 clinical record failed to ensure the his services according to ordered by the physical certification period 10 clinical record failed to ensure the his services according to ordered by the physical certification period 10 clinical record failed to ensure the his services according to ordered by the physical certification period 10 clinical record failed to ensure the his services according to ordered by the physical certification period 10 clinical record failed to ensu	rs for HHA services for the 26/11-11/24/11. The clinical nee a current signed home int sheet signed by the RN. SOC 9/1/11, included a plant HHA services for the //31/11 to 12/29/11. The providence a current signed signment sheet signed by the SOC 10/26/11, included a rs for HHA services for the //26/11 to 12/24/11. The providence a current signed signment sheet had been a by the RN. MENT & DUTIES OF the provides services that are into the plan of care and the to perform under state the provided agency policy and that were into for 2 (A and M) of 2 viewed creating the potential		224			1/16/12
		threat to all patients					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		15K015	B. WIN				C 6/2012	
NAME OF PROVIDER OR SUPPLIER FAITHFUL FRIENDS HOME HEALTHCARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 326 E S MAIN ST GAS CITY, IN 46933			, 5776	0/2012	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
G 225	states, "Take vital sidally records and rethe nursing supervisinclude: observing crecording about the carry out appropriate" 2. On 01-06-12 at 2 health aide (HHA), inhome to patient #10 the patient. She the patient for incontine turned the patient wawakening. She the where she placed that the refrigerator and She then left the patient was breathing. Shome. Upon further had not contacted howhen she was unabindicated the supervicase was for comfor employee A was askwere in place she with recording supervisions.		G	225				
	certification period bidentify only comfort	s plan of care (POC) for the eginning 10/26/11 failed to measures were in place nor e any type of parameters for						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[` '		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUI	LDING	<u> </u>	С		
		15K015	B. WIN	G			6/2012	
	ROVIDER OR SUPPLIER FRIENDS HOME HEALT	HCARE INC		3:	REET ADDRESS, CITY, STATE, ZIP CODE 26 E S MAIN ST GAS CITY, IN 46933			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
G 225	comfort measures. B. The policy titlestates, "In the event to unconscious or the erunconscious he/she solient is breathing and emergency procedure has a pulse, but does call 911 immediately, address and status. Survives, and notify the as possible. C. On 01-06-12 director of nursing, indexing and the doctor measures were needen this was not document patient's record. The policy or procedure in measures would be formal to the policy of the polic	ed "Emergency Procedures" hat the client becomes imployee finds the client should; Determine if the distance has a pulse, do not begin its. If the client is breathing, not regain consciousness, Be prepared to give clients Stay with client until help in nursing supervisor as soon at 3:10 PM, employee U, the clicated that the patient was indicated that comfort ited. Employee U indicated inted anywhere in the agency did not have a place on what comfort collowed or practiced. 25 PM, employee M, a HHA, VS) including blood pressure by the aide on most home indicated the worksheet ites failed to have an area to P taken. Employee M also issisted with the patients in discovery sugars via finger sticks, ed she had no competency just knew how to do it.	G	225				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ultiple (Lding	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		15K015		B. WING 01/			C 6/2012
NAME OF PR	THCARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 326 E S MAIN ST GAS CITY, IN 46933					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION DATE
G 225	B. The patients certification period 1. to evidence an order and perform blood so	POC for patient # 1 for the /18/11 - 1/6/11 (2012) failed for the aide to complete VS	G	225			